OHIO MEDICAID: EFFORTS TO REDUCE INFANT MORTALITY

CURRENTLY UNDER WAY:

1. Presumptive Eligibility at Authorized Sites. Testing is in progress, and nearly complete. Presumptive eligibility should improve enrolling those eligible, impact those at highest risk (mothers of NICU babies), and improve outreach and timeliness of prenatal care.

2. Family Planning SPA (often referred to as a waiver)and Smoking Cessation Coverage (currently underway). Spacing pregnancies at least 18 months after a poor birth outcome improves subsequent outcomes, as doespregnancy preparedness. Tobacco use is another cause of up to 10% of preterm births.

3. "Hands-on" Targeted Case Management for the Managed Care plans. Some of those targeted will be high risk mothers and babies, prompting support of the "HUB."

4. Workforce development through MEDTAPP. Supporting cross-trained community workers as well as primary care nursing and medical personnel who care for women and children.

5. Enhanced Maternal Care for High Risk Pregnancies through Managed Care Plans (MCPs). Using Vital Statistics to identify mothers with prior poor outcomes for whom the MCPs will be responsible for providing enhanced maternal care: centering/group care; maternal PCMH settings; targeting psychosocial risk factors; streamlining referrals to evidence-based programs (Every Child Succeeds, Help Me Grow).

6. Evaluation of the Clinical and Cost- Effectiveness of the Pathways or HUB Model of Connecting to and Coordination of Services. This effort will be undertaken under MEDTAPP, with hopes for alignment with the evaluation of (an upcoming CHIPRA proposalaround) the Lucas County HUB which offers a different context for more complete understanding of the role of such a system.

7. Performance Measurement Strategy for Managed Care. Ohio is currently developing a 2 and 5 year plan to ensure measures (such as the post partum visit measure) used in compliance monitoring and the incentive system are used to drive better outcomes in keeping with Ohio Medicaid's Quality Strategy. Beginning SFY 2013, the CHIPRA Low Birth Weight Measure is a compliance monitoring measure for Managed Care. Beginning SFY 2014, the HEDIS Post Partum Measure will be included in the P4P incentive system for Managed Care.

8. NICU Discharge Planning Collaboration with NICUs and MCP Care Managers. MCPs and NICUs have already completed the first phase of regional meetings to forge partnerships and relationships that may not already exist. The collaborations will focus on streamlining discharge and care management processes, sharing/coordinating appropriate information exchange,

improving coordination between in- and outpatient services to ensure alignment of appropriate clinical providers and services post-discharge, and providing creative avenues for parental education and involvement in their infants care while in the NICU and post-discharge.

9. Managed Care Plans Facilitating the Use of 17P. MCPs are facilitating home visits to provide progesterone delivery for high risk mothers.

10. High Risk Care Management for NICU Infants. Infants who are in NICUs for 7 or more days are required to be in high risk care management if they are enrolled in an MCP. This requirement is coordinated with the NICU discharge planning collaborations.

11. CMS Expert Panel on Infant Mortality (Dr. Applegate is the co-chair of the panel). The panel will make national recommendations on: payment reform; data/measurement strategies; enhanced maternal care benefits; and use of effective reproductive health enablers.

FUTURE PLANS:

1. Progesterone to Prevent Prematurity. Progesterone, a female hormone given by weekly injection or by daily suppository for a short cervix condition, may prevent 20% of preterm births in high risk women. All women who have had prior preterm births (or deaths) are candidates to reduce their risks of future poor birth outcomes. There is also an established screening/identification protocol for all women for primary prevention as there is also evidence that women who have a short cervix (as determined by an ultrasound) are at risk for preterm births. Ohio Medicaid proposed $2M in the budget to support this effort to standardize and spread the ultrasonography methods (to limit false positive and negative results) in conjunction with OPQC (Ohio's Perinatal Quality Collaborative). The funds would allow statewide spread of this best practice for high risk mothers rather than be limited to certain academic centers. Ohio did not "bank" specific savings (although we are aware that the average NICU stay costs $50k) as the rate of practice spread is not clear at this time. A population-based evaluation will be done prior to the next budget cycle to inform next best steps.

2. Performance Measurement Development. Medicaid's personnel budget includes support for at least one research analyst to develop and test more meaningful measures of disparate populations as well as populations we cannot reach through the current HEDIS/NCQA methodology. Some of these efforts are in conjunction with the Medicaid Adult Quality Measures Grant (to be announced within the next month), our Office of Minority Affairs, ODH and national efforts through the CMS Expert Panel, SACIM and ASTHO, to name a few. Ohio ranks 45 out of 50 for infant deaths to Afro American women and 37 out of 50 overall. Our current measurement strategy does not allow us to hold plans accountable for the outreach and action necessary to address these outcomes as we only measure those who seek medical attention in advance of the delivery. Medicaid is moving to a proactive strategy in which we KNOW how many women at risk there are in which regions and we then ask the plans and

providers and communities (Hubs!) to help us find them to get to better outcomes. This measurement development is the foundation of an enhanced care management protocol for high risk women that will be started with the MCPs Spring 2013 (mentioned above) and will be enforced through contract compliance monitoring within the next year as the process becomes institutionalized.

3. Expansion of Eligibility up to 138% FPL. Ohio Medicaid will have the opportunity to reach more women for family planning and ensuring improved health status prior to pregnancies with the expansion of Medicaid to people who have not been previously eligible.

4. Enhanced Care Management Package for High Risk Mothers. This effort may target two groups of women: those continuously eligible, and those only eligible for pregnancy, particularly with the anticipated barrier of getting pregnancy care through the exchange. A faster track for developing the screening and identification protocols for high risk women with the clinically recommended services that include timely access to quality integrated primary and obstetrical care including high risk obstetrical team/PCMH that offers and tracks: control of underlying health conditions, tobacco cessation, BP control, Progesterone, Antenatal steroids, no elective induction/Cesarean Section without medical indication, breastfeeding support, and post partum visit attendance with depression screening to name a few. A strategy may target those with poor outcomes first, expanding to all women at risk. Developing a system (starting with the eligibility system) to not lose track of these women (based on vital stats records and ICD-10 codes) and feeding this info back to Pregnancy Related Services Coordinators or other entities could be avenues ripe for development to drive improved outcomes. In addition, depending on what the future holds for expansion, women who currently receive services at 200% FPL may experience additional barriers in high risk identification and appropriate service deliver if they must go to through the exchange for these services, particularly considering the literacy, cultural competence and immediacy of health care decisions for this population. Work is already underway to begin implementing the enhanced care management package through MCPs.

5. Statewide Neonatal Abstinence Program Implementation. Ohio has many pockets of promising practice around how best to care of opiate addicted babies to minimize length of stay and ensure safety. The development of a new eligibility system and implementation of ICD-10 coding may allow systems changes that immediately identify those at risk to fast track evidence based services to mitigate this problem. Such an effort would be anchored in the PCMH and integrated care efforts in conjunction with ODMH/ODADAS, Criminal justice and child protective services. Ohio Medicaid would ensure that all mothers with these challenges have timely access to evidence-based care, develop the systems efficiencies and communications with toolkits for health care workers with interconnectivity, streamlining through HER vendors, providers and agencies. Success would be measured by a drop in the current 4% of NICU beds filled, with shorter length of stays at lower costs.

6. SIM Grant Planning Phase (accepted by CMS). Ohio is developing proposals for episode-based payments of various groups of episodic clinical care. For peri-natal/postnatal care/delivery services, the goal is to incent providers to deliver appropriate services for each phase of care, linking quality measures to payments. As part of this work, Ohio is establishing a set of "best practices" peri-natal and post-natal services to include within the episode-based payment.

7. Maternal Assisted Treatment for Opiates. Ohio is proposing an effort to standardize evidence-based treatment regimens (Buprenorphine) concurrent with residential and/or intensive outpatient therapy and support for a period of 12-18 months post-delivery for mothers with substance abuse issues. This treatment would extend beyond their Medicaid eligibility, strongly encouraging infants to remain with their mothers and reinforcing the maternal/infant bonding while preventing relapse of substance abuse for the mothers.